Evaluation of Mental Health Awareness Training: A Case Study at HMP High Down

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Associated Reports

National pilot of mental health awareness training:
MUSSELWHITE, C, FRESHWATER, D, JACK, E & MACLEAN, L. (2004) *Mental Health Awareness for Prison Staff.* Bournemouth: Bournemouth University. ISBN 1-85899-135-5.

Evaluation of the video to accompany the training package:
WALSH, E. (2004) *Mental Health Awareness Training for Prison Officers: Evaluation of a Training Video*. Bournemouth: Bournemouth University. ISBN 1-85899-201-X.

Mapping training and education requirements for mental health practitioners:
MUSSELWHITE, CBA, FRESHWATER, D, SCHNEIDER, K & GALVIN, K. (2005). *Mapping of Education and Training for Mental Health Practitioners in the South West.* Bournemouth: Bournemouth University. ISBN 1-85899-194-3.

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Executive Summary

Background

Surveys suggest that 90% of the prison population suffers from mental illness, personality disorder or alcohol or drug dependence, and many suffer from a combination of these (DoH, 2001; Maden et al., 1995; Singleton et al., 1998). Evidently there is a need for prison staff to have high levels of mental health awareness. To meet this need, a mental health awareness training package was developed by the Institute of Health and Community Studies at Bournemouth University to be provided nationally by the Prison Service. The national pilot of this training was successfully delivered in 13 establishments (Musselwhite et al., 2004). Evaluation took place alongside the training and it was established that the delivery framework could be enhanced in three main areas:

- The national training was based on generic mental health needs for prison staff across England and Wales and as such was not specifically applied to local establishment-based issues;
- The national training was delivered over three days with no further formal learning, leaving no chance for working with trainees in post-training sessions to help embed that learning in practice;
- The national training did not allow for evaluation to take place in practice, so assessment of the impact of the training on practice was not possible.

The High Down project built on the national pilot of the training by using a 'case study' approach (Yin, 2003a; 2003b). This approach allowed the training content to be tailored to local need, and enabled follow-up sessions and an in-depth critical evaluation of the impact of the training to be undertaken.

Development of the Training

The following sources of information were used to develop the training for HMP High Down:

- A documentary analysis was used to assess current policy, procedure and practice at HMP High Down;
- Information and knowledge concerning common mental health needs in the prison setting were further developed from the national mental health awareness training package;
- Local needs and issues pertinent to mental health awareness were collected via a training needs analysis undertaken at HMP High Down.

Although the training needs analysis initially suggested that staff wanted training akin to the psychiatric model of mental illness, addressing signs and symptoms and exploring treatment options, there was an underlying need for a more social approach, to help them overcome inappropriate attitudes and prejudice experienced at work. Thus, the training package explored these attitudes by adding a social dimension to the psychiatric model, while retaining a practical focus within which staff could work.

In addition, the training needs analysis showed that staff had limited confidence when dealing with mental health and that there was a lack of time and resources to devote to such issues. Hence, much of the training concentrated on developing confidence and self-esteem and on empowering prison staff to deal with mental health issues in a short time period with little resources. Underpinning this was a conceptual framework to further explore the skills they use, helping them to establish appropriate contextual use of these skills.

The Training Package

The training package was delivered away from the prison establishment, one day a week for three weeks, to 12 prison staff (eight prison officers, three prison nurses and the education liaison officer).

Immediate evaluation of the training was extremely positive and, after one month, staff believed the training had been particularly beneficial in allowing them to:

- Take more time to assess the prisoners' behaviour and treat them as individuals;
- Have more confidence in communicating with the prisoners and following up issues;
- Be more confident in asking prisoners questions about their distress;
- Deal with colleagues who 'put down' efforts to manage the prisoner differently;
- Feel more confident about the referral process and how to refer on;
- Be more willing to engage and connect with prisoners who seem to have mental health problems, rather than ignore them and pass them on to others;
- Act more as interpreter for their colleagues on mental health issues;
- Challenge and question mental health professionals about their assessments.

Continued Learning

Following the three formal training sessions, six one-day follow-up sessions were arranged for the participants to attend, facilitated by the trainers from the three-day training course. Participants directed the content and focus of the sessions. The overall aim of these action learning sessions was to help embed learning in practice, with the hope that individuals would build on their mental health knowledge and skills, and develop their attitudes and confidence so that they could lead on such issues within HMP High Down in the future. The concept of providing post-course support through reflection and action learning was welcomed by course participants and enabled the further development of skills when dealing with prisoners who have mental health issues.

Conclusions and Recommendations

Overall, the sessions were evaluated favourably and although the three-day training course gave the group a great deal of knowledge and understanding, it was the action learning group meetings that improved their confidence in dealing with mentally ill prisoners and in working effectively in an interprofessional context. This has helped staff to become a mental health resource with the ability to lead on these issues as appropriate. As such, it is suggested that they could become a useful liaison between mental health specialists (such as in-reach teams, GPs and psychiatrists) and the prison environment (including prisoners, prison officers and governors) to reduce the gap between mental health professionals and prisoners.

The success of the package means that other prisons should consider adopting such a methodology for delivering mental health awareness training. In turn, mental health networks could be established nationwide to share good practice and continue learning from each other.

Introduction

Background and Context

Since 1997, the prison population has grown by 20% and is now at record levels, with a total population of around 74,259 prisoners (HMPS, 2005). With an annual throughput of approximately 200,000 people, and a population predicted to expand beyond the limits of prison capacity, the scale of mental healthcare need in this population is significant.

The Office for National Statistics surveys from 1997 and 1998 state that 90% of prisoners have a mental illness, personality disorder or alcohol/drug dependence. Often, prisoners have a combination of multiple disorders in addition to substance misuse (usually referred to as dual diagnosis) (DoH, 2001; Maden et al., 1995; Singleton et al., 1998). Singleton et al. (1998) claim that 9% of male prisoners and 13% of female prisoners suffer from schizophrenia, compared with around 0.5-0.8% of the general population. Furthermore, Singleton et al. (2001) cite that 59% of male prisoners and 76% of female prisoners suffer from a diagnosable neurotic disorder compared with 13.6% of males in the general population and 19.4% of females. Singleton et al. (2001) also state that 78% of male prisoners and 50% female prisoners suffer from a personality disorder compared with 5.4% of males and 3.4% of females in the general population. In addition, 15% of male prisoners and 30% of female prisoners attempt suicide per year, and 5% of male prisoners and 10% of female prisoners self harm (Singleton et al., 1998).

It has been reported that standards of healthcare within prisons are poorer on the whole than those found in the National Health Service (NHS) (HMIP, 1996; Reed & Lyne, 1997; Smith, 1984). This is especially true in the case of mental healthcare and service provision (Health Advisory Committee for the Prison Service, 1997; Plant et al., 2002). A recent Department of Health publication, *Changing the Outlook* (DoH, 2001), states the need for the NHS and Prison Service to work together in a formal partnership to overcome health inequalities found within prisons, not least in the mental health arena. Standards of mental healthcare in prisons must also meet the criteria set out in the National Service Framework for Mental Health (DoH, 1999), which states that local services must explore opportunities to 'improve mental healthcare for prisoners within existing resources' (DoH, 1999, p9). Paton & Jenkins (2002) suggest that this can happen through:

- Supporting the governor and other staff to develop an environment that supports mental health and well-being;
- Identifying prisoners with mental and substance abuse disorders;
- Managing prisoners with common mental disorders;
- Referring appropriately for assessment, advice or treatment;
- Providing information and guidance for those who provide regular and substantial care for prisoners with mental health problems – in prison, this is often staff as well as family members;
- Contributing to multidisciplinary work to prevent suicide.

In addition, it is anticipated that, despite the scale of need among the prison population, the majority of mental health issues could be addressed within prison and do not require hospitalisation (DoH, 2001).

It is clear that there is a need for training and support for all prison staff in mental health awareness. There is a particular need for wing-based officers to help them:

- Identify prisoners at risk of developing mental health problems;
- Identify prisoners experiencing mental health problems;
- Respond appropriately to the needs of these prisoners.

Underpinning this is the notion of equality; that is to say, prisoners should receive the same level of mental healthcare as those in the general population.

Pilot of the National Mental Health Awareness Package

To meet the training and development needs of prison staff caring for prisoners with mental health issues, a mental health awareness training package was developed by the Institute of Health and Community Studies (IHCS) at Bournemouth University to be provided nationally by the Prison Service. The national pilot of this training was successfully delivered in 13 establishments (Musselwhite et al., 2004). Evaluation took place alongside the course and it was established that the delivery framework could be enhanced in three main areas:

- The national training was based on generic mental health needs for prison staff across England and Wales and as such was not specifically applied to local establishment-based issues;
- The national training was delivered over three days with no further formal learning, leaving no chance for working with trainees in post-training sessions to help embed that learning in practice;
- The national training did not allow for evaluation to take place in practice, so assessment of its impact on practice was not possible.

Mental Health Awareness Training at HMP High Down

A Case Study Approach

IHCS at Bournemouth University was commissioned by East Elmbridge and Mid-Surrey Primary Care Trust to provide mental health awareness training for staff at HMP High Down. HMP High Down is a local, category A, male prison and holds up to 736 prisoners. At that time, IHCS was involved in developing the national mental health awareness training package for HM Prison Service. The High Down project built on the national pilot of the training by using a 'case study' approach (Yin, 2003a; 2003b). This approach allowed the training content to be tailored to local need, and enabled follow-up training sessions and an in-depth critical evaluation of the impact of the training to be undertaken. Accordingly, the following aims and objectives were adopted:

Aim

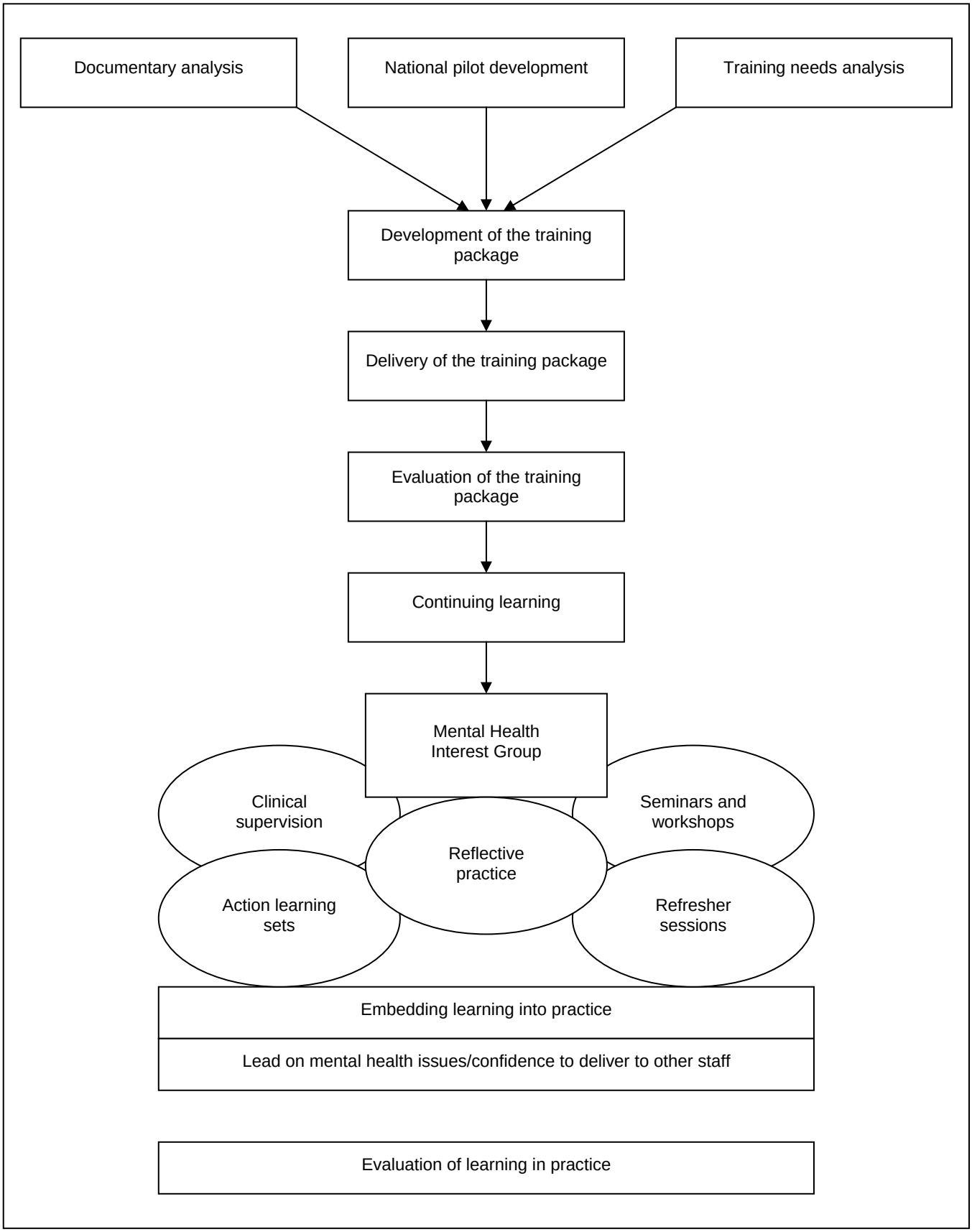
- To develop, deliver and evaluate a mental health awareness training package tailored to meet the local needs and issues of HMP High Down by adopting a case study approach.

Objectives

- To develop a mental health awareness training package for prison officers at HMP High Down, based on the local functional, operational, cultural and training needs of staff at HMP High Down;
- To deliver high-quality mental health awareness training to prison officers at HMP High Down;
- To evaluate the mental health awareness training package for prison officers at HMP High Down in light of local needs and issues;
- To evaluate the impact of the mental health awareness training package on the prisoners, staff, operations and services at HMP High Down;
- To facilitate continuous learning to embed the training into practice through the use of reflection, supervision and action learning sets, thereby enabling individuals to develop confidence to lead on mental health issues at HMP High Down;
- To analyse the effectiveness of using a locally tailored model of training compared with a national model.

The method used to develop the case study approach to mental health awareness training at HMP High Down is set out in Diagram 1. The case study followed a participatory enquiry methodology in which staff helped to inform and shape the direction of the project.

Diagram 1: Development of the case study approach to mental health awareness training at HMP High Down.



Developing the Training

Background

The following sources of information were used to develop the training:

- A documentary analysis was used to assess current policy, procedure and practice at HMP High Down;
- Information and knowledge about common mental health needs in the prison setting were further developed from the national mental health awareness training package;
- Local needs and issues pertinent to mental health awareness were collected via a training needs analysis undertaken at HMP High Down.

Documentary analysis

HMP High Down and East Elmbridge and Mid-Surrey Primary Care Trust provided background information about current mental health policy and procedure, including a recent confidential review of mental health services and care pathways. These documents were reviewed, and so contributed to understanding the context of mental healthcare at the prison and subsequently the perceived need.

Learning from the national mental health awareness training

The national pilot of mental health awareness training underpinned the case study approach. The development of the national training made use of the following resources:

- A scoping exercise of current policy initiatives within prison healthcare, secure environments and policy directives, e.g. *Provision for Mental Health Care in Prisons* (Health Advisory Committee for the Prison Service, 1997), *National Service Framework* (DoH, 1999) and *Changing the Outlook* (DoH, 2001).
- A review of current mental health awareness packages and training:
  - *Mental Health Primary Care in Prisons* (Paton & Jenkins, 2002);
  - *Mental Health Training Pack* (Keir et al., 2002) developed for HMP Winchester;
  - *Mental Health Training for Prison Staff* (Wilson, 2003) developed for HMP Morton Hall;
  - *Screening for Mental Illness in the Youth Justice System* (Youth Justice Board, 2003);
  - *Introduction to Mental Health* (Pearson & Sheers, 2003) developed for HMP Bristol;
  - *Skills-based Training On Risk Management* (STORM) (University of Manchester, 2004) developed for HM Prison Service and commissioned by Safer Custody;

  - *Mental Health First Aid Manual* (Kitchener & Jorm, 2002) developed by Mental Health Research at the Australian National University, Canberra, Australia;
- Interviews with key stakeholders, including prison staff, mental health trainers, Department of Health Prison Healthcare staff and Safer Custody staff;
- Mapping of capabilities and skills to be addressed in the training package using *The Capable Practitioner* (SCMH, 2001) and *National Occupational Standards for Mental Health* (Skills for Health, 2004) (see Musselwhite et al. (2004) for complete methodology).

Training needs analysis

A qualitative approach was used to undertake a training needs analysis of the mental health training and development requirements of staff at HMP High Down. Interviews were carried out with six members of the prison staff, examining four levels of training need:

- Functional (how the prison is run as a whole);
- Operational (how the prison operates day-to-day locally within groups and teams);
- Cultural (global attitudes of staff at the prison);
- Individual (related to current competencies and skills of staff).

The interviews and focus groups differed from the 'traditional' semi-structured method by incorporating dialogical versions of need generation theory (Robertson, 2000; Robertson & Robertson, 1999) and included abstract theory, apprenticing, brainstorming and scenario modelling. Themes were coded and the findings subsequently validated in a focus group where all six members of staff were asked to refine and clarify the main needs and requirements identified. The reflective nature of the process not only helped identify conscious needs (as traditional semi-structured interviewing does), but helped to elicit pre-conscious needs and generate 'undreamed of' needs (Robertson & Robertson, 1999). To this end, the technique was useful for generating training needs for which the training package was subsequently developed.

Content Development

Taking into account the knowledge gained from the three approaches outlined above, a training package was developed by staff within IHCS at Bournemouth University and from Prison Health (Department of Health) to address mental health awareness training specifically for staff at HMP High Down. Although some of the content was similar to the national package, other aspects were specific to routines and procedures at HMP High Down and incorporated many new areas of interest pertinent to that particular prison. Table 1 offers a summary of the main research findings.

The training needs analysis highlighted that much of the job of prison staff was dealing with mental health issues. The main areas of mental illness seen in the prison environment about which more information was needed were anxiety disorders, psychosis, schizophrenia, depression, dual diagnosis, personality disorders, self-harm and suicide. These correspond with figures of prevalence highlighted in previous studies (Maden et al., 1995; Singleton et al., 1998). In addition, self-harm and suicide needed to be studied separately from each other in terms of mental health. Given the high prevalence of suicide and self-harm in prisons, this is unsurprising (Maden et al., 1995; Singleton et al., 1998).

Interestingly, the approach of staff during the training needs analysis was initially similar to the dominant psychiatric model of mental illness. Staff wanted to explore further some of the diagnosable mental illnesses, stating that they wanted to see signs and symptoms and address treatment options. Further exploration of this issue highlights that prison staff are open to interpreting many of the 'illnesses' in a more social manner. This helps them to overcome many of the prejudices and problems with labelling that they experience during their work. The training builds on previous training packages that explore these attitudes and adds a social context to the psychiatric model (Musselwhite et al., 2004; Wilson, 2003), while retaining a practical focus within which staff can work. This is particularly useful in this case study where staff highlighted problems in identifying signs and symptoms early on, showing that, through facilitated discussion on mental health issues, the learning had already begun for the staff. The methods adopted in the training needs analysis therefore enabled individuals to begin discussing, learning and addressing new ways of looking at aspects of mental health.

Table 1: Summary of mental health training needs identified among prison staff.

Identified training need	Summary
General mental health awareness	Understanding of key mental health issues and illnesses is required for all staff, including: • Signs and symptoms, referral processes and management of psychosis, schizophrenia, depression, personality disorders, self-harm and suicide; • Differences between self-harm and suicide need to be highlighted and discussed; • Crisis management skills need to go beyond restraint techniques; • Training should be practical and include practical examples of mental health in prisons, including different examples of remand and convicted prisoners; • Equipping staff with skills that help them predict violent behaviour; • Equipping staff to deal with manipulative situations; • Understanding and developing care pathways; • Understanding the diagnostic tools used (2052SH and ACCT process).
Confidence	Prison staff feel their skills are underdeveloped or unfocused and have little confidence in using them.
Reflection on practice	Reflection on good practice is rare, since no formal training takes place. (See Freshwater et al., 2001; 2002).
Communication skills	Better communication and understanding of principles and practice between healthcare and discipline staff are needed, including: • Improvements in sharing information, such as better referral language by discipline staff, better use of day-to-day observations given to healthcare staff, better understanding by discipline staff of what is likely to happen to referred cases, and better understanding is needed by discipline staff of what has happened to prisoners in healthcare on their return to the house blocks, including noting any potential changes in behaviour that can be expected; • Responsibility of medication to be levelled with both healthcare and discipline staff, so more knowledge of medication is needed; • Better understanding of roles and responsibilities of healthcare staff by discipline staff and vice versa; • Team-building and teamwork exercises needed between staff.

cont./

Table 1 cont.

Appropriate referral from house blocks to healthcare	Fewer referrals made to healthcare since some cases could be better managed on the house blocks. This would require officers to be better at managing certain mental health issues. This could be achieved by: • Development of better therapeutic communication skills; • Better knowledge of other therapeutic interventions; • Confidence in their ability to 'talk' to prisoners.
Medication knowledge	Medication knowledge needs to be enhanced for all staff, including: • Understanding side effects of some drugs; • The effects of missing medication; • How to identify symptoms of missed medication; • How to recognise side effects of medication; • How to distinguish between different drugs; • Why different drugs are administered for different conditions.
'Local' prison issues	Remand prisoners have distinct needs that must be reflected in a training package and should cover: • Why quick fix solutions are not always appropriate; • Identification of signs and symptoms early on in relationships.
Leadership	Staff should be developed as 'experts' to lead on mental health issues (one or two per house block and some from healthcare). They should: • Offer advice and guidance on mental health issues; • Take workshops and/or seminars on mental health issues; • Aid mental health professionals in their role.

Similar to research undertaken for the national mental health awareness project (see Musselwhite et al., 2004), there is a notion that staff do not feel confident in effectively supporting, managing or caring for prisoners with mental health issues. The training needs analysis highlighted that most staff have good skills and an appropriate attitude when dealing with mental health issues in the prison environment, but that these are not fully utilised because of concerns over confidence and lack of time and resources. Hence, much of the training developed must deal with raising confidence and self-esteem, and empowering prison staff to deal with mental health issues in a short time period with little resources. Underpinning this is a conceptual framework to further explore the skills they use, which helps to suggest appropriate use of the skills contextually. Other training packages addressing mental health issues in prisons also dealt with this problem (e.g. Musselwhite et al., 2004; Paton & Jenkins, 2002; Pearson & Sheers, 2003; Wilson, 2003).

The training needs analysis identified a requirement for training in communication, sharing information and working with other groups. Specifically, better training to facilitate links and communication between healthcare and discipline officers is required, for example issues about medication. This covers additional material not previously addressed in mental health training packages (Keir et al., 2002; Musselwhite et al., 2004; Paton & Jenkins, 2002; Pearson & Sheers, 2003; Wilson, 2003).

It was important to the staff taking part in the training needs analysis that the training was contextualised in a prison setting for it to be useful. This supports the research carried out for the national package (Musselwhite et al*.,* 2004). Furthermore, it was highlighted that the facilitator of the training should have experience to draw on. This supports previous research highlighting that trainees need to have confidence in those that teach them. Such facilitators should not just have knowledge of practice but should be immersed in their practice and should therefore bring their own lived experiences to the learning (Andrewes et al., 1999; Redwood et al., 2002).

Phase One: Delivery and Evaluation

Delivery

As with the national pilot and other research into practice development within prison healthcare, the concept of delivering the training away from the prison establishment and out of uniform was felt to be important (Freshwater et al., 2001; 2002). This promoted an informal, relaxed learning environment, which was important considering the topics being discussed and the need for participants to reflect on their own experiences, both professional and personal. Delivery of training took place over three days – one day per week for three weeks – which totalled approximately 18 hours of contact time throughout April 2004. This approach enabled staff to reflect on the previous session during their working week and bring issues from practice to discuss at the beginning of the next training session.

This training was originally aimed at prison officers. However, from discussions with the prison it became apparent that healthcare staff and other departments also wished to take part. Consequently, the training was devised for a multi-disciplinary group, which helped to address some of the problems associated with interprofessional working. In total, 12 participants took part and turned up to each of the three sessions. There were eight prison officers, three general healthcare nurses and one education liaison officer. Training was undertaken by two trainers with considerable experience of the prison setting in terms of health, and by a senior lecturer with a background in psychology and mental health.

The High Down training comprised five modules:

- Module 1: Background to understanding mental health and illness
- Module 2: Mental health awareness
    - Anxiety disorders
    - Depression
    - Bi-polar disorder
    - Psychosis and schizophrenia
    - Co-morbidity, substance misuse and mental illness
    - Personality disorders
- Module 3: Understanding self-harm and suicidal behaviour
- Module 4: Communication and documentation skills
- Module 5: Team working and perceived barriers.

Table 2: Training needs and modules.

Identified training need	**Modules covering the need**
General mental health awareness	Across all modules
Confidence	Across all modules
Reflection on practice	Across all modules
Communication skills	Modules 4 and 5
Appropriate referral from house blocks to healthcare	Modules 2, 4 and 5
Medication knowledge	Module 2
'Local' prison issues	Across all modules
Leadership	Modules 4 and 5

Table 2 highlights how the training needs were met in each module. As can be seen, most modules were adapted for the specific training modules. In particular, Modules 4 (communication and documentation skills) and 5 (team working and perceived barriers) were developed as a result of the training needs at HMP High Down.

All course participants were given a student handbook containing the slides used for each module and the theory discussed. Space was also provided for participants to add their own notes. All participants were asked to complete a questionnaire to evaluate their experiences. These questionnaires were completed anonymously at the end of each session and broadly covered the following issues:

- Methods of delivery and content;
- Prior knowledge and experience of mental health;
- Overall length and logistics of the training days;
- Overall issues and concerns with the training package.

Evaluation

Day One (modules covered: 1, 2a, 2b, 2c, 2d)

A questionnaire was given to all participants comprising questions about the content of the training, the standard of course delivery and prior knowledge of mental health issues. All participants completed and returned their questionnaires at the end of day one.

All reported that they had enjoyed the modules covered throughout the day, with many stating that they found all the sessions very informative. Respondents also commented that group work and working in pairs was useful for providing a multi-disciplinary perspective that promoted team building. Course participants were asked to indicate their prior knowledge of the subjects discussed during day one. The majority reported that they

knew some of the material, having dealt with mentally ill prisoners. Some participants also mentioned that mental health had been an issue in their personal life. Only two highlighted that they knew very little of the material prior to the training.

When asked about the quality and content of the teaching, all course participants reported that they found it 'good' or 'very good'. Some added that they liked the way questions could be asked freely, that the material was well presented and that they felt their input was valued by the trainer. In terms of the course so far, one respondent stated:

> *'Today has flown by and left me with a thirst to learn so much more in the area of mental health. I particularly like the handout so I can do further reading before next week.'* (1)

In addition to questions about the content of day one, participants were also asked to reflect on the impact that the training may have on their everyday practice and if they would recommend this training to their colleagues. All staff replied that they felt the training was useful, as they had learnt from it. All but two of the respondents reported that they would be doing things differently when they got back to work. When asked to elaborate on what they would do differently, two of the respondents stated:

> *'I will not take any behaviour for granted.'* (2)

> *'…looking more actively for signs of prisoners with mental health issues.'* (1)

All respondents felt the training was relevant to them, although two suggested that it would be better placed within prison officer basic training or earlier on in the prison officer career. When asked if they were surprised by anything they had learnt during day one, one participant noted her surprise at how little she knew and another learned about the actual nature of schizophrenia as opposed to the media portrayal.

Overall, day one was a success, with participants learning new information, beginning to feel part of a team and enjoying the relaxed mode of delivery. In particular, the tutor was praised for her use of personal experience to explain theoretical perspectives.

Day Two (modules covered: 2e, 2f, 3)

Again, a questionnaire was completed and returned by all participants at the end of the day. The questionnaire addressed issues concerning the delivery of the training and the content. In addition, participants were asked to disclose their prior training in self-harm/suicide awareness.

All theory modules were rated very highly and were described as 'good' or 'very good'. Those participants who elaborated on their choice of answer stated:

> *'I used to think self-harmers were attention seekers – now I know better.'* (B)

> *'PD presentation and info very useful to me as was s/harm lesson. Substance misuse very useful to know and v. relevant to prisons.'* (C)

> *'Enjoyed very much.'* (D)

Participants were then asked about previous training in suicide and self-harm in addition to their contact with prisoners who self-harm. All but two of the participants reported that they frequently or very frequently have contact with prisoners who self-harm. However, of these replies, three did not have any previous training in suicide and self-harm or could not remember undertaking any. All other respondents had frequent or very frequent contact with self-harm and had undertaken previous training provided by the Prison Service, either during their initial prison officer training or while at HMP High Down.

All participants reported that they would recommend this training to their colleagues and the majority felt that the training would make a difference to the way that prisoners were treated.

All feedback on the second day was very positive in terms of both content and delivery. When asked to rate the day out of 10, the mean score given was 9.1.

Day Three (modules covered: 4, 5)

Day three incorporated the modules on communication/documentation skills and team working/perceived barriers, which were delivered using group work activities and discussion. Again, all participants reported that they enjoyed the day, found it interesting and felt that it was relevant to their job. The majority of the group enjoyed the style of delivery:

> *'Very relaxed and student led/friendly.'* (i)

> *'Very lively.'* (ii)

> *'I've enjoyed the interaction within the group.'* (iii)

Participants were asked to state what they had enjoyed least about day three. There were only two responses:

'Nothing. Most relevant training apart from basic.' (iv)

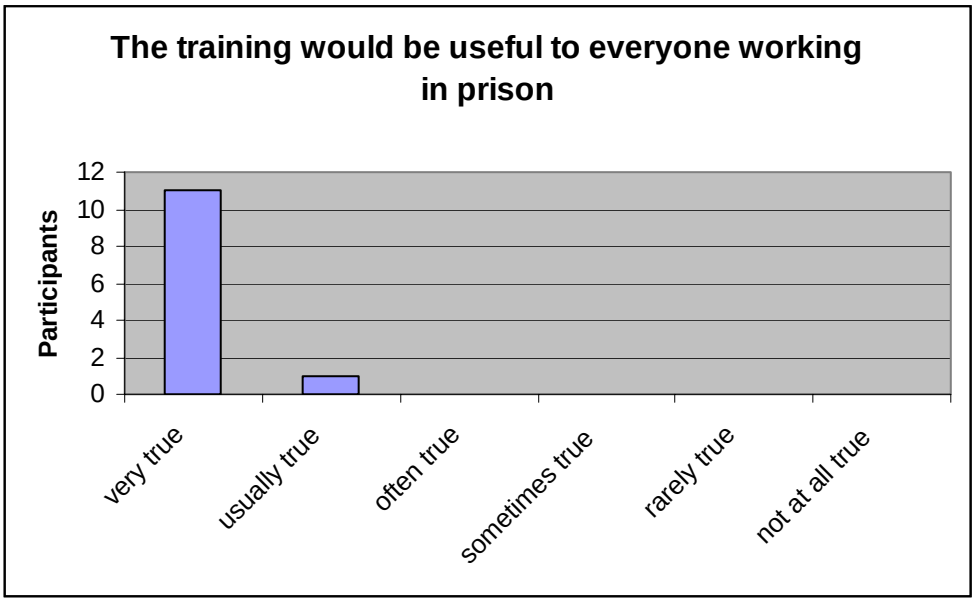
'Enjoyed all aspects.' (v)

Respondents were asked to rate the training for the final day from 0 to 10 where 10 was very good and 0 was very poor. An average of 9.75 was obtained.

Overall evaluation of the three-day training course

Participants were asked to provide an overall evaluation of the three-day training course. This information was collected via the use of a questionnaire, which was completed by all and returned at the end of the third training day. The questions asked centred on the appropriateness of the training for both HMP High Down and the Prison Service nationally, the impact of the training in terms of knowledge acquisition and content, and the effect of the training on the personal development of participants. As shown in Figure 1, many participants felt the training would be 'very useful' for everyone working in the Prison Service.

Figure 1: How useful would the training be to those working in the Prison Service?



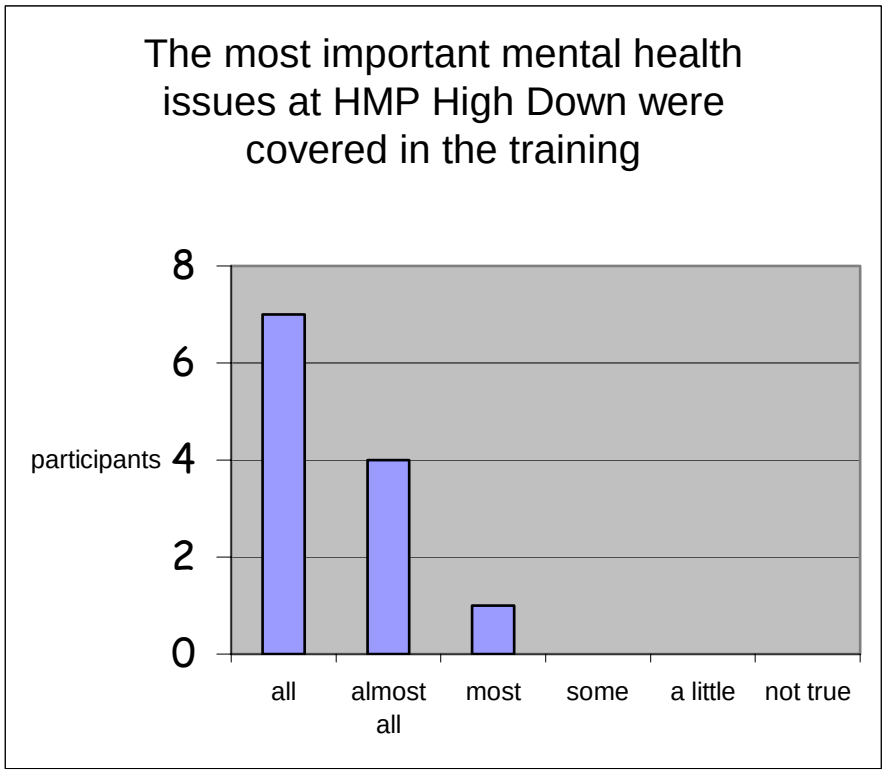
All but two participants felt the training had taught them a lot about themselves. All respondents replied that they would like to learn more about mental health issues. Nine participants felt they would treat prisoners better in the future. In addition, one participant stated:

'I didn't shy from dealing with mental health prisoners but this course has given me the tools to deal with them.' (vi)

In terms of attitude change towards prisoners with mental health issues, all participants felt their attitudes had changed for the better.

Participants were asked if it was true that the content of the training addressed the specific needs of HMP High Down staff. Figure 2 shows that all participants felt it covered the most important issues, with seven participants stating that they felt it covered all important mental health issues.

Figure 2: Were the most important issues covered in the training?



Participants were asked to highlight the module they liked best from the whole course. Half the respondents stated that they liked all the modules and could not choose one over the others. One participant added:

> *'I have enjoyed the three days. It has been the most interesting and beneficial course that I have attended in recent years.'* (i)

Other modules highlighted were the understanding mental health and illness module (n=3), the mental health awareness module (n=2) and the communication module (n=1).

When asked which modules they liked least, five respondents did not answer. Of the remaining respondents, two highlighted the suicide and self-harm module, one the understanding mental health and illness module, one the team working and perceived barriers module, and three

the communication and documentation skills module. Those that highlighted the suicide and self-harm module added that they were already trainers in the field and found it a little repetitive.

Participants were asked to add any mental health issues they felt were missing from the training. Only two responded. One mentioned obsessive-compulsive disorder and the other stated that they would have liked more information about self-harm behaviour in prisoners withdrawing from drugs and alcohol.

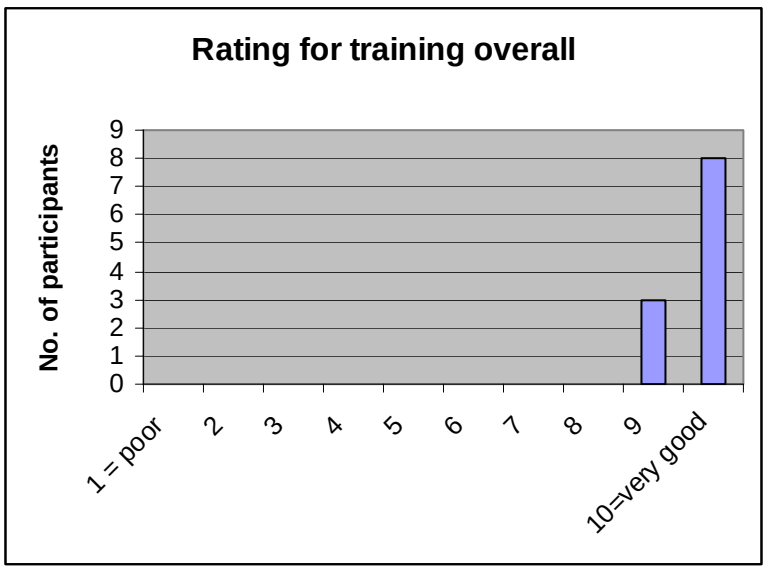
In terms of the pattern of course delivery (i.e. once a week for three weeks), participants were invited to comment on their preference. Three participants did not reply. Of those that did, all felt that having one day per week for three consecutive weeks was ideal because it allowed the assimilation of knowledge in practice:

> *'Once a week for three weeks enabled information to be digested and implemented.'* (i)

> *'Once a week gave me time to digest the info delivered as opposed to consecutive days where maybe I would have felt swamped by information.'* (viii)

Finally, participants were asked to rate the training from 0 to 10, where 0 was 'very poor' and 10 was 'very good' (see Figure 3).

Figure 3: Participants' rating for the training overall.



Phase Two: Continued Learning

Action Learning Group

Following the three formal training sessions, six one-day follow-up sessions were arranged for the participants to attend, facilitated by the trainers from the three-day training. Participants directed the content and focus of the session. Again, meetings were facilitated away from the prison and were held monthly between June and December 2004, allowing for a break during August.

The overall aim of these action learning sessions was to help embed learning in practice, with the hope that individuals would build on their mental health knowledge and skills, and develop their attitudes and confidence so that they could lead on such issues within HMP High Down in the future. In the first instance, the concepts of action learning (McGill & Brockbank, 2004) and reflective practice (Johns & Freshwater, 1998) were presented to the group with the aim that they could be used during the sessions and between sessions back at the prison. In addition, the sessions were also useful for clarifying knowledge, promoting new ways of working and acting as a refresher to the course. All employees were invited to attend, and lunch and refreshments were provided. The group was facilitated by the tutor who provided the initial training and by a prison health researcher from Bournemouth University. This ensured continuity and allowed participants to further explore issues raised during the training. Although a facilitator attended each session, the group was encouraged to contribute and make the sessions their own. Following the final session, the group was encouraged to meet again without formal facilitation. A follow-up session in May/June 2005 was planned to assess any further developments.

The evaluation of the action learning group was undertaken by the facilitators on a monthly basis, where notes and observations were recorded and analysed to elicit any changes or developments that had taken place both within the group and in their reported practice. A questionnaire was delivered at the final action learning group to formally evaluate the effectiveness of this mode of learning.

The concept of providing post-course support through reflection and action learning was welcomed by course participants and enabled the further development of skills when dealing with prisoners who have mental health issues. A record was kept of the issues discussed and progress made within the group. Participation in the action learning group

was discussed at the outset of the monthly meetings and, although some staff expressed concern that they may not be able to attend every session, every effort to do so would be made.

It was originally thought that the training and subsequent support would be sufficient to enable participants to deliver mental health awareness training to other members of staff at HMP High Down. Following the training, this was discussed and it was felt by the group that they did not have the skills or expertise to deliver such training, despite having undertaken the course themselves. This is reminiscent of concerns regarding sustainability in other prison healthcare research (see for example Freshwater et al., 2001; 2002)This caution expressed by the staff was echoed in the national pilot, where the concept of using the training to train trainers has since been abandoned. Although staff could be given the information to impart to others regarding mental health issues in prison, it was felt by both High Down staff and by staff nationally that the information must be contextualised and the trainer needs to be able to draw on their own experiences and knowledge base to answer questions and promote correct practice.

It is this element of training that caused the most concern for staff. Once this was addressed within the group, it was decided that using the monthly meetings to address mental health issues that came to light between meetings would be the best course of action. In adopting an action learning group approach, this learning could be more structured. In addition to this, it was decided that articles of interest from the media, current developments in practice, and training on how to reflect in a structured way to promote experiential learning would be addressed in the sessions. Consequently, although the participants would not be able to formally deliver training, the group could be seen as a mental health resource to HMP High Down staff and lead on such issues where appropriate.

What follows is a précis of the six sessions of the main discussion points. Not all specific information concerning each group is provided for reasons of confidentiality, but the highlights and issues that the group agreed to share are reported.

Session One: June 2004

This meeting was very productive and a plan for the subsequent meetings was discussed. On the agenda for these sessions would be discussion concerning examples of practice experienced during the month that could be looked at by the group. These could include incidents concerning prisoners with mental health issues, examples of good practice, areas where clarification was needed and issues with

other colleagues in the management of prisoners with mental health issues. Further areas for training that could be addressed in future sessions were also identified. Furthermore, it was suggested that using one of the days to visit another mental health area, such as Broadmoor hospital, regional secure unit or another prison, would be beneficial.

To enable participants to begin undertaking structured reflection, time was spent during this session on looking at the purpose of reflection and at an example of a model of structured reflection (see Johns, 1995). This model was used as the basis for a discussion about reflective practice and a simplified model of reflection was distributed (see Appendix 1). It was felt that asking them to complete structured reflection would give the group a focus for discussion at the next meeting.

In addition, the concept of action learning was addressed. According to McGill & Brockbank (2004), action learning is:

> '…a continuous process of learning and reflection that happens with the support of a group or 'set' of colleagues, with the intention of getting things done' (p11).

Action learning was deemed to be the most appropriate strategy for embedding the theory learnt during the training into practice because it gives participants the opportunity to learn by reflection between meetings and use the action learning group as a way of discussing their learning, developing their skills and initiating change in the workplace and their own practice. The use of the action learning set provided participants with a safe environment in which to discuss their learning and subsequently develop strategies for changing practice. Both the concepts of reflection and action learning were well received by the group and their benefits acknowledged.

To examine the initial impact of the training during the first month, the participants were asked to highlight areas of their practice that had changed. As Table 3 shows, some of the training needs highlighted by the High Down staff were being met through the training and continued reflection. This is particularly true in terms of confidence in leading on mental health issues among staff, between different disciplines of staff and also between staff and prisoners.

Table 3: Areas of practice highlighted by participants as having changed as a result of the training, mapped to initial training needs.

Identified training need	Summary of changes in practice
General mental health awareness	• Taking more time to assess a prisoner's behaviour and treating them as individuals. • Assimilating information received from the prisoner in a different way. • It is more of an automatic response to view the prisoner from this new perspective. • Can 'tag/label' and deal with the prisoner more effectively. • Have been shown gratitude by prisoners in distress, because of the way they have been dealt with. This led to feeling more valued and worthwhile in their roles.
Confidence	• Having more confidence in what is said to the prisoners and following up issues. • Not being afraid to ask prisoners questions about their distress.
Reflection on practice	• More frustrated at times because now realise there is a need, and sometimes this need cannot be addressed due to regime, colleagues and other professionals.
Communication skills	• Dealing with colleagues who 'put down' efforts to manage the prisoner differently.
Appropriate referral from house blocks to healthcare	• Feel more confident about the referral process and how to refer on. • More willing to engage/connect with prisoners who seem to have mental health problems rather than to ignore and pass on to others.
Leadership	• Acting more as interpreter for their colleagues, because they demonstrate credibility and understanding of the issues. • More willing to challenge/question mental health professionals about their assessments.

Following this, examples of practice causing concern for individuals were discussed and addressed by the trainer, researcher and other members of the group. Action plans were devised and individuals were asked to update the group at the next meeting. In addition, it became clear that there were areas that the group needed to address via more training and development, such as:

- More skills-based training to enable more effective delivery of interventions e.g. pacing, mirroring, matching and leading;
- More communication skills in dealing with difficult colleagues;
- Strategies for making connections and short interventions to be used when dealing with mentally ill prisoners;
- A better understanding of the role of the in-reach team.

Session Two: July 2004

This session was not as well attended as the first for a variety of reasons. However, it was decided that the group should still meet as arranged for continuity. Interestingly, there was no representation from healthcare

which it was felt could promote a 'them and us' culture with discipline colleagues, and therefore have an effect on the action learning philosophy of the group. The concept of action learning was discussed again, along with some of the topics raised at the last session, and participants brought with them issues to discuss. Much of the discussion centred on dealing with difficult colleagues rather than on prisoners with mental health problems. However, these issues could be related to some of the theory taught during the training. Strategies for dealing with difficult colleagues were raised and action plans devised. It was clear after this meeting that the group needed to maintain a focus on addressing issues concerning mental health in prison rather than dealing with difficult colleagues, but the effect on the mental health of the staff was addressed.

Session Three: September 2004

During this session, a video, made to complement the national mental health awareness training, was shown to the group and stimulated much discussion, which was directed to link with the theory taught previously. This was timely as it gave the participants an opportunity to reflect on their own experiences and refresh their memories about the initial training they had undertaken. Again, an action learning philosophy was adopted and individual issues were aired and discussed. Those who raised issues at the last meeting also presented feedback from the last session. In addition, participants were given a copy of media articles concerning the Mental Health Bill that was in the news at the time. Its potential effect on prison health and the care of mentally disordered offenders was discussed in terms of the impact on discipline staff in prisons.

Session Four: October 2004

Unfortunately, attendance at this session was very low. Out of 12 original participants, only three took part in this meeting. Annual leave, days off and work commitments were reasons given. This session began with a reflection and discussion of how the programme and training had affected the practice of those present. Issues highlighted by the participants included:

- More confident in making referrals to mental health services within the prison;
- More confident in challenging and dealing with other members of staff when caring for prisoners with mental health issues;
- Better able to undertake assessments of prisoners with suspected mental health issues;
- Better able to assess body language;
- More confident to act on intuition with prisoners causing concern;
- Now beginning to question the mental health of colleagues.

In addition to reflecting on the progress made by these participants in dealing with mental health issues at the prison, other points for discussion were raised concerning best practice. Lengthy discussion on the use of the F2052SH system and caring for prisoners at risk promoted further thought about the system and dealing with prisoners suffering mental health problems. Discussion about working relationships with other officers when dealing with prisoners was also lengthy. Action plans were discussed for implementation before the next meeting, as was the perceived need by the group for managers and governor grades to undertake training in mental health awareness.

Session Five: November 2004

This session began by re-visiting the issues raised in October, as many of the group had not been present. Feedback was given by those who had attended concerning the work they had taken with them from the last meeting. Some issues raised had been successfully resolved, others not. However, more action learning was undertaken, with all participants given time to discuss their own concerns and issues. What became clear to both facilitators was that the nature of the issues raised appeared to centre on working relationships between basic grade officers and middle management. Although not particularly focused on the mental health of prisoners, these issues were taking their toll on the mental health of the participants. Problem-solving strategies were discussed for future implementation and clear themes emerged in terms of development requirements of the group. Dealing with conflict, assertiveness and empowerment were highlighted by the facilitators as issues to be addressed during the final session.

The concept of reflection was also revisited during this session. All participants had been given information about structured reflection using a model. Although none had returned to the group with a completed written reflection since, the idea of reflection was positively received and the group appeared to be more reflective at work as a consequence of attending these sessions. Some members reported that they had reflected on their work and learnt from it.

Participants also discussed their changing practice since undertaking the course and attending the action learning group. Of interest was the overwhelming feeling that they were now more confident in their dealings with mentally ill prisoners and had begun to view them differently i.e. as unwell rather than attention seeking. It was reported that they were now more aware of what is normal and what is not. In addition, some staff highlighted that their colleagues had begun to treat them in a different way, paying more attention to their views when dealing with mentally ill prisoners.

An interesting outcome of the action learning process was the confirmation of the need for systematic structured time out from clinical practice to reflect. This reinforces the findings of previous and ongoing research that aims to develop a national strategy for clinical supervision across the prison service and forensic mental health settings.

Session Six: December 2004

The final session was used to consolidate the learning from the previous months and re-visit any areas of the training the group felt they needed to address. Much time was spent during this session looking at the concept of empowerment in practice and focusing on what they had achieved throughout the training. Strategies were discussed concerning participants' working relationships with colleagues and future developments in their own practice. One such development was the future of the group as a vehicle for their individual professional development and that of their colleagues in mental health issues. The group was encouraged to continue meeting and developing their interest in mental health. The possibility of organising a visit to a local secure unit or Broadmoor hospital was discussed. At the end of this session, participants were given the contact details for the facilitators and encouraged to keep in touch. A questionnaire to evaluate phase two of the training was completed by all present.

Evaluation

Of the original 12 participants who undertook the mental health awareness training, only six were present at the final action learning group. Interestingly, these six had been the core members of the action learning group and were all prison officers. All completed a questionnaire and returned it at the end of the final meeting. The questionnaire was devised to elicit information about the three-day training, the action learning group and the future plans of the participants in terms of continuing with the group.

Section One: Three-day training

Section one of the questionnaire asked about the three-day training. Although this could be seen as repetitive, significant time had passed since the completion of this training, with the addition of further development, and so attitudes and thoughts about it could have changed. In this sense, the researchers were hoping to access any latent learning that had taken place. Participants were asked to state which of the original modules they could remember and to describe how they had affected their practice. All remembered undertaking the modules concerning specific mental health issues, but some could not remember undertaking the modules on communication or team working.

Of those that responded and elaborated on how the training had affected their practice, the theme of increased confidence was evident:

> *'Given me the confidence and understanding of mental health – thank you.'* (D)

> *'More confident with all prisoners, more relaxed around prisoners with mental health issues and a keenness to know more.'* (E)

Also evident was how participants had changed in the way they dealt with prisoners experiencing mental health problems:

> *'Looking and listening more, making that extra time for listening and watching.'* (C)

> *'I can relate more with self-harmers and show empathy.'* (F)

> *'I analyse prisoners' behaviour in more depth. I try to be more patient with difficult, challenging prisoners instead of generalising bad behaviour/attitudes.'* (B)

Section Two: Action learning groups

Participants were then asked to comment on the action learning groups. Of the six respondents, two had attended all six sessions, one had attended five, two had attended four and one had attended three. Reasons given for non-attendance ranged from work commitments, personal reasons, sickness and annual leave/days off. Only one reported that they were unable to get time off work to attend.

Respondents were asked for their opinion on the action learning groups. All replies were positive:

> *'Very practical and useful.'* (F)

> *'Excellent. Time to discuss events that have affected us. Share experiences and express ideas.'* (E)

> *'Very good. More broken down. A time to relate on issues and cases at work and outside work.'* (C)

> *'Given me more confidence in speaking up at work when I think a prisoner needs help (i.e. someone to talk to) and may be suffering with a mental illness.'* (D)

Interestingly, two respondents highlighted how the action learning group had given them the opportunity to reflect on their own mental health:

> *'Quite deep at times and an interesting exercise in self analysis.'* (B)

> *'I felt I learnt a great deal from the follow-up sessions and gave me an insight into myself both personally and professionally.'* (A)

Participants were then asked to think about how the action learning groups had affected their own practice. As was demonstrated with the three-day training, the action learning groups gave some participants more confidence when dealing with prisoners and other staff:

> *'Yes, I am now able to feel more confident when dealing with clients who suffer from mental illness, but am aware of my boundaries.'* (A)

> *'I refer prisoners to in-reach with a confidence I never had previously i.e. I no longer worry if I've asked for a prisoner to be assessed and it turns out that he doesn't have mental health problems.'* (B)

> *'Speaking more directly about mental health issues to prisoners. Speaking to mental health professionals more confidently using the correct language to communicate symptoms and behaviours. Making more time to listen to prisoners who are genuinely expressing their fears and concerns.'* (E)

> *'More interaction with prisoners who are suffering from mental illness in any shape or form, not being scared of their condition and talking about it with other colleagues and bosses.'* (D)

One respondent demonstrated that they now use a more reflective approach:

> *'I am looking more at each situation as it arrives and thinking about the outcome more.'* (C)

Section Three: Future plans for group meetings

Finally, participants were asked to think about the future and if they would consider continuing to meet as an action learning group. All reported that they would like to continue to meet as a group. They were asked to identify the resources they would need and any barriers to continuing to meet. The two main resources identified were time and a venue, although

one respondent suggested that this would not be a problem as they would be happy to meet at someone's house or go for lunch as a group. Barriers to meeting included differing shift patterns and problems arranging a time when all were free.

Summary

As can be seen, the three-day training and the subsequent action learning group meetings were all evaluated very positively. Although attendance was poor at some of the meetings, there was a core group of staff who consistently attended and, as shown by the evaluations, gained a great deal. This mode of training and support is not common practice within the Prison Service. Although the three-day training did appear to give the group a great deal of knowledge and understanding, it was the action learning group meetings that improved confidence in dealing with mentally ill prisoners and in working effectively in an interprofessional context.

Recommendations & Conclusions

Due to the need for mental healthcare in prisons (Singleton et al., 1998; Singleton et al., 2001) and the nature of the prison environment, mental health training for all members of staff is vital. HMP High Down was given an opportunity that not only trained staff on general mental health issues, but was designed to meet specific issues at that prison, involving follow-up action learning and reflective group work to help embed the training in practice. This focused approach has created a richly aware and confident mental health resource. The training allowed reflection on practice for the participants, resulting in an increased self-awareness and a clearer understanding of job role, allowing time for the support of prisoners rather than a simple security focus. The training also afforded increased communication skills between different groups of individuals. The participants felt particularly that they were able to engage better with prisoners and spend more time with them. In addition, they felt more able to communicate with other staff and between staff from a variety of agencies. As a result, they felt their opinion on mental health issues was being listened to, which overall helped to improve their job satisfaction.

The training delivered at HMP High Down took place during a national pilot of mental health awareness training for prison staff. Some of the key learning points from the case study approach have been included in the recommendations for the roll-out of the national package. It was suggested that the national course should be delivered one day a week for three weeks, rather than on consecutive days, to allow time for reflection. In addition, the HMP High Down case study approach suggests that allowing time for reflection and action learning following the training is successful in helping to embed the training in practice. Any national roll-out should consider using this approach. Furthermore, because communication was identified as an issue in the training needs analysis and was also frequently mentioned during the evaluation, it was proposed that the module on communication and documentation skills should be included in the national mental health awareness training.

However, as noted in the success of the HMP High Down case study approach, training can be tailored to the needs of individual prisons rather than a national generic workforce. Throughout the modules, and especially in the follow-up reflective sessions, examples from the prison were used and the topics were contextualised within HMP High Down policy and procedures. The national package cannot be so specific and, as such, loses some of its saliency. Delivery of the national package to specific prisons should involve some prior research of the local establishments to help contextualise the information.

Frequently mentioned throughout the evaluation was how communication was improved as a result of the training and how the confidence of participants grew. In turn, individuals were happy to lead on mental health issues in appropriate circumstances. The concepts of enhanced communication skills, increased confidence and leadership tend to develop through interactive-style workshops focusing on group work. These skills are also best learnt over time within a reflective framework (Freshwater et al., 2001; 2002). The HMP High Down case study approach, with its focus on interactive group work and follow-up reflective sessions, enabled individuals not only to have better mental health awareness but also better communication and more confidence in using their awareness within their role. In turn, this has helped them to become a mental health resource and to be able to lead on such issues as appropriate.

The newly trained staff at HMP High Down should be used to the full. They should be seen as a liaison between mental health specialists and social care workers (such as in-reach teams, psychiatrists and GPs) and the prison environment (such as prisoners, nurses, officers and governors). This role would see them able to negotiate the sometimes problematic differences between people with limited mental health awareness but rich everyday experience with prisoners, and those with mental health expertise but little everyday contact with the prisoners. The gap between the mental health professional and the prison officer and prisoner is therefore reduced.

In addition, it is hoped that the group can help impart their mental health knowledge to other colleagues. This should happen informally as part of the job, but could also happen more formally with participants leading seminars or discussion groups on the topics. This might be particularly useful for supporting, mentoring or helping individuals who receive the national mental health awareness training at HMP High Down. It is also hoped that further case studies such as the model at HMP High Down will take place throughout the country at other establishments. If this is the case, participants from all the prisons could form a national mental health awareness group to share good practice and continue the learning from each other.

Finally, the success of the package also suggests that mental health awareness training is required for other people in the prison environment. For example, it was frequently mentioned throughout the evaluation of the training that those at senior level, particularly governors, would benefit from such training. It has also been mooted that prisoners themselves could benefit from the training.

Summary

Overall, it can be seen that the case study approach with HMP High Down has been extremely useful in creating awareness of mental health issues among prison staff. In addition, the model has enabled staff to have better communication skills when dealing with mental health issues. There has been better reported communications between members of staff and between staff and other agencies, as well as, importantly, between staff and prisoners. This has enabled prison staff to view their role as more than merely custodial and has helped them to engage in a more social supporting role. The reflective sessions, in particular, enabled individuals to grow in confidence with regard to their mental health knowledge and skills. This, coupled with increased confidence in communication, has meant that participants have begun to lead on such issues within the prison environment and have become a resource to fill the gap between everyday prison routine and the mental health expert. The future could involve many exciting developments for them, such as mentoring others in gaining mental health awareness and possibly liaising with other mental health resources across the country.

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Appendix 1

Model of Reflection Used by the Group

(Devised using Johns (1995) and Boud et al. (1998))

This model was given to participants on one side of A4 paper and was designed as a questionnaire.

- What happened?
- How did you feel at the time?
- What was good/bad about the experience?
- What sense can you make of the situation?
- What else could you have done?
- Action plan: What would you do next time?
- What have you learnt (both professionally and personally)?